INSTITUT C.D. HOWE INSTITUTE

COMMENTARY
NO. 410

# The Case of the Vanishing Québec Physicians: How to Improve Access to Care

*Québec has a greater number of family doctors relative to the population than Ontario, but scores much worse in terms of patient access to care. The author examines the issue and what to do about it.*

Claude E. Forget

## About The Author

Claude E. Forget
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Commentary No. 410
May 2014
Healthcare Policy

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$12.00
ISBN 978-0-88806-931-3
ISSN 0824-8001 (print);
ISSN 1703-0765 (online)

## The Study In Brief

Compared to most Canadian provinces, Québec is endowed with a large and fast growing number of family doctors relative to its population. In spite of this, Québec's family physicians and the general public regularly report that provincial residents have poor access to healthcare services. This *Commentary* examines this paradox, looking at what has held back past reforms to primary care and what to do about it.

In 2012, there were 115 family doctors in Quebec for every 100,000 people, compared to 100 in Ontario and 109 for Canada as a whole. But roughly 15 percent of Quebec patients report not having a regular family doctor compared to about 4 percent of Ontarians. Further, 68 percent of Quebecers reported having a "somewhat" or "very difficult" time accessing after-hours care versus 58 percent of Ontarians. Why?

Quebec physicians tend to spend less time at work than their counterparts in Ontario. Quebec stands out as an exceptional case among most developed countries for the shortest physician's work week at 34.9 hours, compared to 43 in Ontario. Younger doctors (under age 45) work even less, at 32.7 hours per week. Quebec also has fewer enrolled patients per physician, 1,081 on average compared to 1,539 in Ontario. These numbers are lower still for younger doctors.

Over the last decade, Quebec has attempted, with little success, to improve primary-care access with the creation of family health teams. But Quebec's Groupe de Médecine Familiale expansion has been fraught with delays and, even where groups have sprung up, they are enrolling a much lower number of patients than desired.

A renewed, determined effort at primary-care reform with stronger financial incentives and commitment from governments and providers is required. Financing these teams through a mixed capitation system that encourages patient mobility, registering with family doctors and physician accountability in meeting access benchmarks should go a long way to strengthen the pursuit of better access for patients. Such a model could be extended in the future to allow primary-care givers greater budgetary control to purchase some basic services on behalf of their patients. Physician buy-in and a willingness to provide more primary care in the community as opposed to hospitals are key ingredients of a successful transition.

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**Easy and reliable access to primary care is important for several reasons. Primary care serves as the entry point for more specialized healthcare services.**

It delivers a large volume of care for less complex problems. Primary care also provides care continuity because of the links it provides between individuals, families and caregivers, including post-hospitalization follow-up. As well, primary care is central to chronic illness treatment. Finally, through preventative measures, it can reduce the need for more specialized and expensive healthcare services.

This *Commentary* argues that although Quebec has more family physicians per capita than most provinces, its results on measures of access to care are poor compared to many other public health systems, including Ontario's. In light of the Quebec government's slow, and largely unsuccessful, plan to encourage better primary-care access over the last 10 years, this *Commentary* identifies ways to address this failure. For example, more effective primary-care delivery can be achieved by altering modes of practice and by aligning financial incentives that encourage doctors to both take on more patients and offer more care in the community as opposed to in hospitals, where too much care is currently delivered.

Quebec's primary-care failures have little to do with the general principles that have driven its healthcare policy in the last decade. Instead, the lack of a sense of urgency on the part of government and healthcare providers has failed to drive the change process forward. Renewed efforts should build stronger financial incentives into remuneration schemes for primary-care teams with a greater emphasis on per-patient (capitation) funding that encourages patient mobility, registering with family doctors and physician accountability to access measures. It's also imperative that Quebec makes compensation levels for primary care delivered in the community at least as generous as in the hospital system.

## The Access Issue: Many Quebecers Go Without Family Doctors

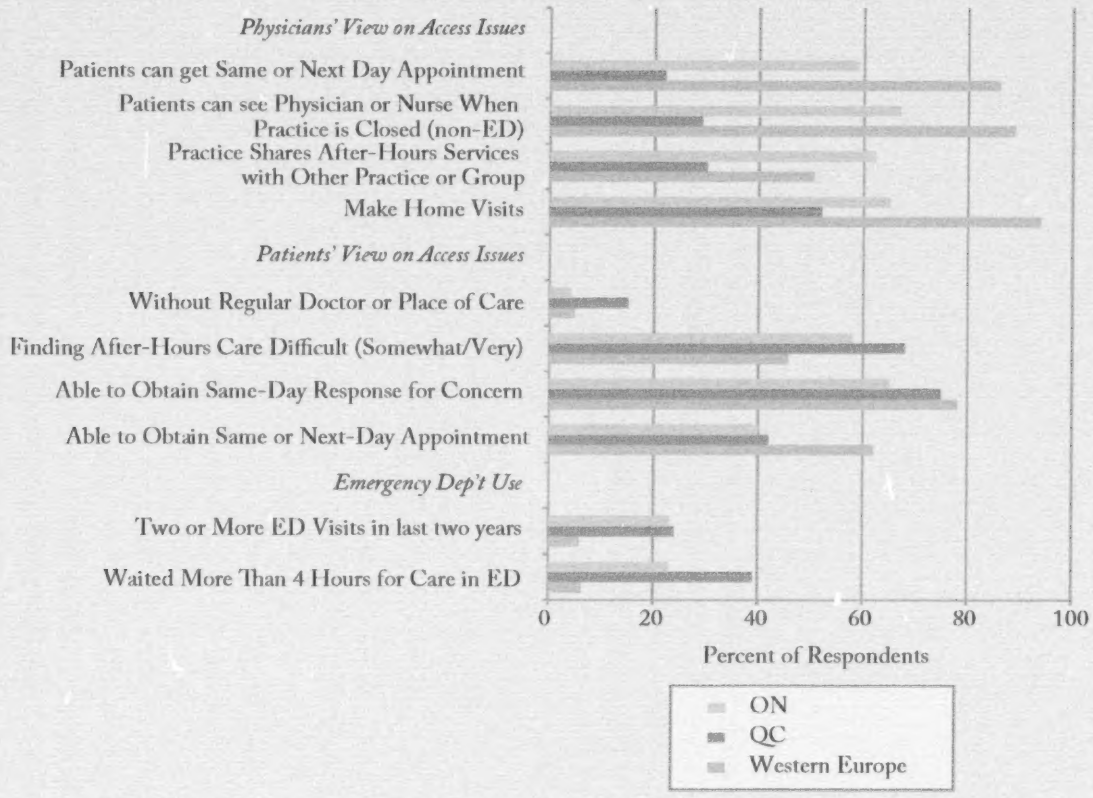
Quebec's relatively poor performance on primary-care access is illustrated by comparing its results for access criteria with Ontario's, as well as with four West European countries (France, Germany, the UK and the Netherlands). Ontario is chosen as a comparator because it is the best-performing province in this regard and has undergone recent reforms to further improve primary-care access.[1]

Western European results on primary-care access measures outshine those in Ontario and the European countries perform vastly better than Quebec (See Figure 1). This holds true whether one asks the general public or primary-care doctors about the availability of same-day or next-day

I want to thank all those who generously spent time with me to discuss the issues involved in this *Commentary*, or read and comment on early drafts. This applies to Jacques Brunet, Marie Dominique Beaulieu, Richard Cruess, Antoine Groulx, Louis Godin and John Richards. A special thanks is due to Colin Busby without whose support this *Commentary* would not have been written.

1 Alberta and/or BC occasionally demonstrate marginally better performance than Ontario.

## Figure 1: Access to Care: How Quebec Compares


Physicians' View on Access Issues
Patients can get Same or Next Day Appointment
Patients can see Physician or Nurse When Practice is Closed (non-ED)
Practice Shares After-Hours Services with Other Practice or Group
Make Home Visits
Patients' View on Access Issues
Without Regular Doctor or Place of Care
Finding After-Hours Care Difficult (Somewhat/Very)
Able to Obtain Same-Day Response for Concern
Able to Obtain Same or Next-Day Appointment
Emergency Dep't Use
Two or More ED Visits in last two years
Waited More Than 4 Hours for Care in ED
0
20
40
60
80
100
Percent of Respondents
ON
QC
Western Europe

Notes: These results are based on the Commonwealth Fund Survey results from the 2012 survey of primary-care physicians and the 2013 general public survey. The results are based on surveys of about 390 doctors and over 1,000 patients in Quebec; 500 doctors and more than 1,500 patients in Ontario, and 2,500 doctors and roughly 4,500 patients in the four European nations.

Sources: HCC (2014, 2013) and CSBE (2012(2)).

appointments, after-hours care availability and being enrolled with a regular family doctor's practice.[2]

The Quebec findings are particularly gloomy. Roughly 15 percent of Quebec patients surveyed report not having a regular family doctor compared to about 4 percent of Ontarians and 5 percent of western Europeans. Furthermore, 68 percent of Quebecers reported having a "somewhat" or "very difficult" time accessing after-hours care (versus 58 percent of Ontarians and 46 percent of

2 The latter can be used to better schedule and organize needed tests or preventive care, medication and annual review of medication and management of chronic conditions.

Europeans), and only 42 percent reported being able to obtain a same-day or next-day appointment (about the same as the 40 percent of Ontarians but much worse than the 62 percent of Europeans).

Primary-care physicians in Quebec have a pessimistic outlook, similar to citizens, when it comes to accessing primary care. Fewer than one in four (22 percent) said that their patients could get a same-day or next-day appointment, whereas 59 percent of Ontario's doctors and 86 percent of those in western Europe said patients could get a quick appointment when needed. Furthermore, when their practice is closed for the day, only 29 percent of Quebec doctors said a patient could get an appointment with another doctor or nurse compared to a 67 percent positive response in Ontario and 89 percent in western Europe.

One area where there is a significant difference between Quebec and Ontario, on the one hand, and western Europe, on the other, is emergency department (ED) usage. In western Europe, there is much less reliance on EDs for primary-care issues – roughly 6 percent of people reported that they visited an ED two or more times in the last two years. Meanwhile, in Quebec and Ontario the equivalent reliance was four times greater – one in four (24 percent) of Quebecers and Ontarians reported high preferences for ED care (Figure 1).

But once they entered the ED, Quebecers experiences were much less satisfactory than if they had been in Ontario or western Europe. Almost 40 percent of Quebecers reported waiting more than four hours for care in EDs, compared to 23 percent in Ontario and 5 percent of Europeans. Much of the difference in accessing primary care and not visiting EDs seems to be explained by the availability of after-hours care. On this score, western European countries offer much more after-hours care than Quebec or Ontario, though Ontario still vastly outperforms Quebec in this area.[3]

## The Paradox: Quebec Has More Doctors per Capita than Most Provinces

What makes Quebec's results on these cursory measures of primary-care access perplexing, even paradoxical, is that Quebec is endowed with a large and rising number of family physicians. In 2012, there were 115 family doctors in Quebec for every 100,000 people, compared to 100 in Ontario and 109 for Canada as a whole (Table 1). From 2007 to 2010, the Quebec population increased by 3.8 percent while the number of doctors jumped 10.2 percent. So doctor shortages are not a cause of primary-care access issues in Quebec – Quebec family physicians are 15 percent more numerous relative to the population than their Ontario peers.

Why so many family doctors and so little availability by comparison with other provinces? There are some plausible reasons.

Since the inception of Medicare in Quebec in 1970, provincial policies have tended to encourage family physicians to work in institutional settings. The government strongly supported the admission of family physicians as full-fledged members of hospital medical teams, and it granted them equal fees with specialists for common medical procedures (mostly to be found in the hospital

3 Other interesting differences among Quebec, Ontario and western Europe regarding the quality of primary care are also found in these surveys. In western Europe, for example, there is poor coordination of primary-care providers with the general healthcare system. In general, few primary-care providers are systematically notified of their patients' presence in EDs, few get reports from specialists and many report that their patients have difficulty getting specialized diagnostic services. In all these respects, Ontario does as well as western Europe – not a high hurdle – but Quebec lags far behind.

Table 1: Number of Physicians per 100,000 Population (by province, 2012)

| | NL | PE | NS | NB | QC | ON | MB | SK | AB | BC | YT | NT | NU | CAN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Family Medicine** | 126 | 98 | 127 | 117 | 115 | 100 | 102 | 100 | 110 | 122 | 155 | 60 | 26 | 109 |
| **Medical Specialists** | 114 | 84 | 123 | 104 | 120 | 102 | 91 | 80 | 107 | 99 | 30 | 23 | 9 | 106 |

Source: CIHI (2013).

setting). As a result, family physicians received a professional as well as an income boost.

These policies have worked to the extent that community hospitals are now staffed and run mainly by family physicians – and hospital work accounts for just under half of their time, according to their association, the Fédération des Médecins Omnipraticiens du Québec (FMOQ). Some 1,400 of them staff EDs, including those of teaching hospitals.[4] This has made hospitals dependent on family doctors, such that in 2002 the provincial government made it a legal obligation for designated family physicians to provide stand-by and actual availability for some EDs at certain periods of time.[5]

Community health clinics, called Centres Locaux des Services Communautaires (CLSCs), were established initially with a salary-based compensation set at an income enhancing level. In Quebec, 15.7 percent of primary care doctors practice in community clinics compared to 9.2 percent in Canada as a whole (CSBE(1)).

In both hospitals and community clinics, Quebec family physicians enjoy exceptional support, which they do not pay for, from an average of 6.1 other healthcare professionals compared to an average of four for similar facilities in Canada as a whole. This support rises to as many as 12.1 professionals in CLSCs. Other things being equal, such a level of support should allow family doctors to look after more patients and provide better services. In practice, however, it appears that the way physicians are compensated gives them less incentive to supply easily accessible primary care to large numbers of patients in these environments than in their individual practices where they are paid more on a fee-for-service basis.

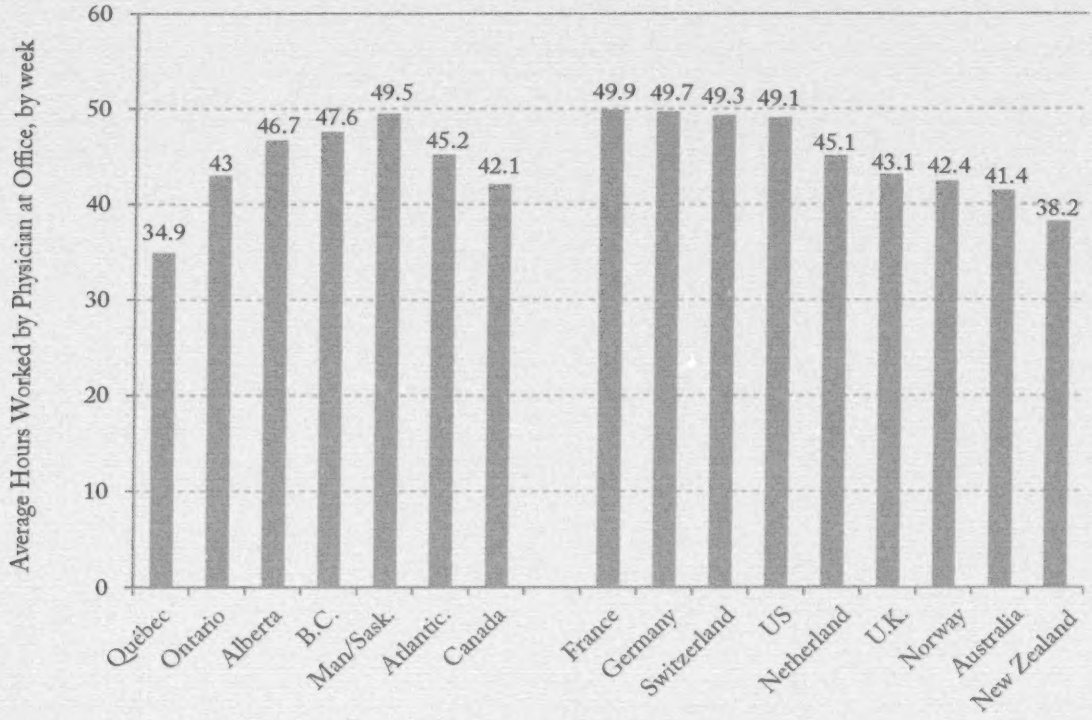
The growing appeal of institutional practice for physicians is gradually replacing the small enterprise environment of the private doctor's office where one has to choose a smart location, make an investment and pay staff. Today, younger, and often female, physicians are particularly attracted to these institutional settings (CSBE 212, Garmier 2013). Institutional settings, although better endowed, tend to be more bureaucratic and provide weaker incentives, resulting in less access to regular primary care.

Another factor impacting on patient access is that Quebec physicians tend to spend less

4 See Godin (2010).

5 In 2013, they were paid $5,060 per week just to be on stand by and $4,365 per week to actually provide the services, in addition to the fees for services earned in the process (*Lettre* 2013). These amounts are set annually through a *lettre d'entente*. More recently, a sessional fee (a salary-like form of payment) has been introduced for family doctors when caring for in-patients.

Figure 2: Hours Worked by Primary-Care Physicians (weekly, provincial and national averages, 2012)



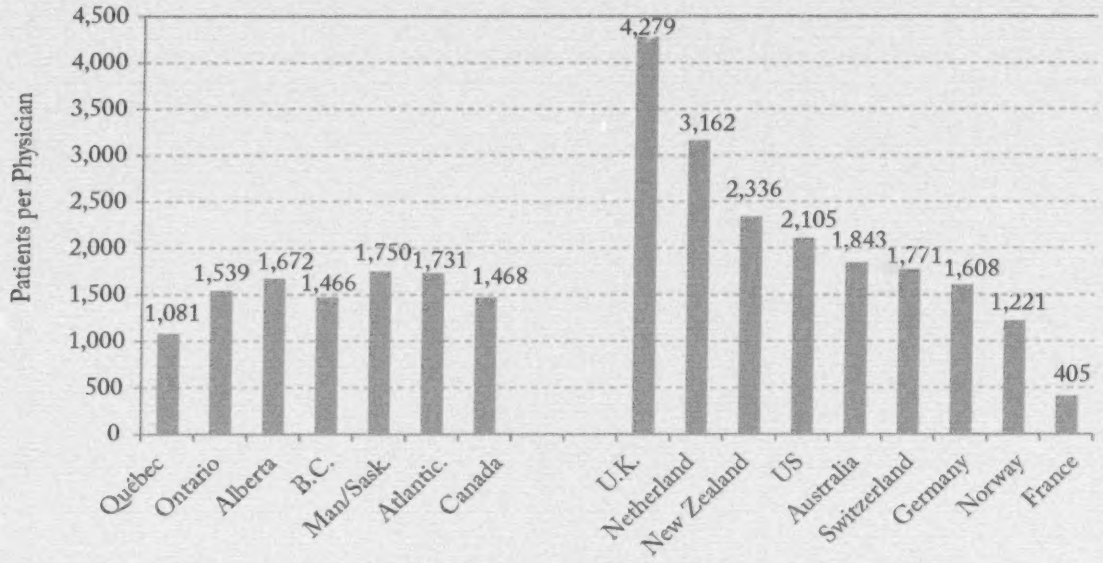

Source: CSBE (2012a, 121).

time at work than their counterparts in Ontario. Indeed, Quebec stands out as an exceptional case among most developed countries for the shortest physician's work week at 34.9 hours, compared to 43 in Ontario (Figure 2). Younger doctors (under age 45) do even "better" at 32.7 hours, 31.8 for those in CLSCs and 30.9 for female doctors.

Quebec also has fewer enrolled patients per physician, 1,081 on average compared to 1,539 in Ontario and an astounding 4,279 in the UK (Figure 3). These numbers are still lower again for younger doctors, doctors in CLSCs and female doctors (CSBE 2012).[6] This relatively low level of physicians' time with patients in their offices and

6 The relatively low hours worked for female physicians are a new development for the medical field. Their rapid entry into the profession – they are at 42.2 percent of all family doctors in Quebec, compared to 35 percent in Ontario (CIHI 2012) – may conceivably demonstrate to their male colleagues that fewer hours are possible and acceptable. High remuneration may also produce a greater preference toward leisure, particularly for those working in institutional settings, resulting in reduced working hours. These factors are at play elsewhere in the world; Quebec may just be displaying the effects more rapidly (Contandriopoulos 2007).

Figure 3: Average Number of Patients per Physician (by province and country)




Source: CSBE (2012a, 125).

the fewer patients in their care are directly related: the 19 percent fewer hours makes up a good part of the 30-percent-fewer patients per physician vis-a-vis Ontario.[7]

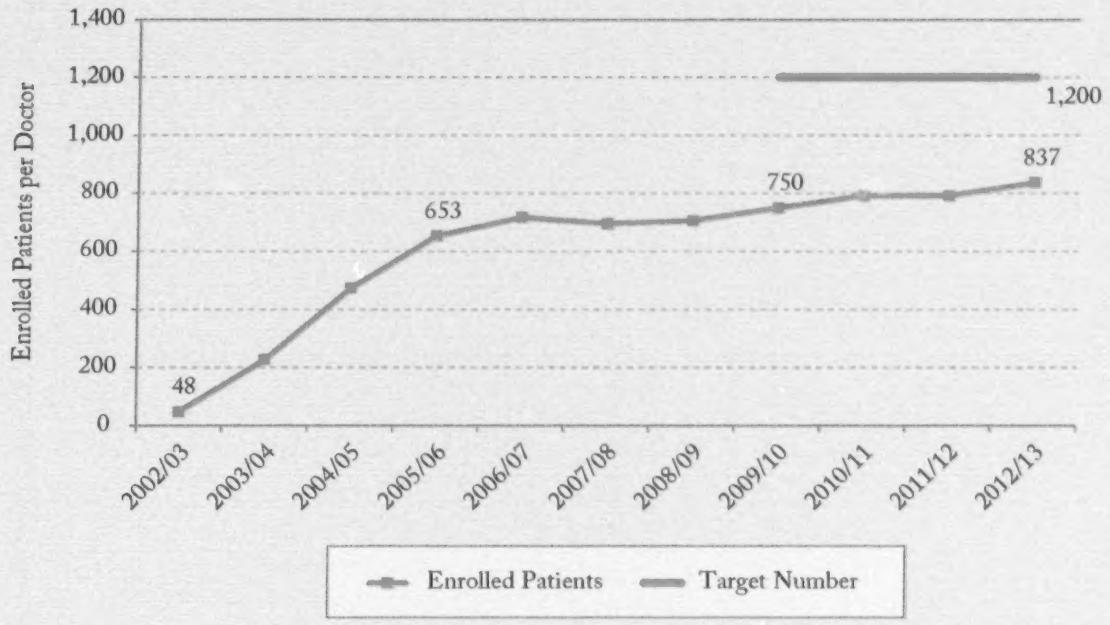
### The Limited Success of Quebec's GMF Initiative

Over the last decade, Quebec has attempted, with little success, to reform, en masse, primary-care access with the creation of family health teams – Groupe de Médecine Familiale (GMF). Based on the 2001 Clair Health Review Commission's recommendation to establish GMFs, the government created health teams comprised of family physicians, working in cooperation with nurses and other healthcare professionals, to offer a broad range of primary-care services to registered patients, who were encouraged to enlist with doctor groups (Clair 2001). The plan was to develop up to 300 such groups, for them to be open five evenings a week as well as for a minimum of five hours on Saturdays and Sundays.

But Quebec's GMF expansion has been fraught with delays and, even where groups have sprung up, they are enrolling a much lower number of patients than desired. Over the last 10 years, the government has not met its target of 300 groups, partly because family doctors have been reluctant to enlist in the program, especially in Montreal. The plan's goal was to have, with near province-wide coverage, an average load of between 1,200 to 1,500 patients

7 Increases in fees paid to physicians may well contribute to a reduction in available services. See Contandriopoulos 2013(2).

Figure 4: GMF Patient – Enrolment Rates per Doctor Below Target (2002/03-2012/13)




Sources: Hebert (2012); author's calculations.

per physician[8] – well above the present average of only 837 patients registered with each of the 3,784 GMF physicians (Figure 4).

There are many potential reasons holding back the roll out of new GMFs. Examples include newly enlisted doctors who join a GMF with an already established list of patients that they consider sufficient, and who face little monetary incentive to enrol more patients.[9] The relationship between the hours family physicians spend in emergency departments (as well as in many other roles in community hospitals) – which family physicians claim take up about 40 percent of their time – or their after-hours presence at their family practices has not been clarified. Although the latest figures show some improvement in the number of enlisted patients, the penetration rate of GMFs in the overall population remains low (Godin 2010).

8 See Beaulieu et al. (2006, 1). Note that the Ministry of Health and Social Services goal in 2002 was to have about eight to 10 physicians and two nurses per group.

9 GMFs are comprised of some 10 full-time equivalent family physicians, not necessarily in a single location. Upon qualifying, a GMF receives two registered nurses, an administrative assistant and a secretary in addition to any existing staff. GMFs are mostly in private physicians' offices, but they get financial assistance for the extra space required for the four extra staff. Physicians receive a payment for "taking charge" of the patients on their lists (a form of capitation) and a number of other payments for high-needs patients, in addition to the regular fees for the services they provide.

Another reason for the slow growth of GMFs is that healthcare professionals have struggled to work collaboratively and divide duties within a team-based setting.[10] While the government recognized the need to train nurse practitioners and enhance their scope of practice in primary-care reform plans, their training program was arguably underfunded. Another challenge: the GMF program is remarkably little known by the general public, slowing down registration rates.[11] And, finally, while politicians and the media have denounced GMFs that have failed to deliver the essential after-hours requirement, they appear to persist without appropriate sanctions (Hebert 2012).

In short, implementation for most GMF policies has been slow or deficient – neither doctors nor patients are enlisting at a fast enough rate.

## Desirable Characteristics of a Better System

Improving access to primary healthcare in Quebec should be feasible provided that the following interdependent issues are tackled.

### *1. A Better Balance between Primary Care and the Rest of the Health-Services System*

Quebec would have a more than adequate number of family physicians if only they shifted their main focus of interest away from institutional settings toward primary care in neighbourhoods. Government should ensure the financial and professional conditions for family physicians drive physicians in the right direction, while understanding, and if possible counteracting, the tendency toward a shorter work week.

Even so, while family physicians would remain the core of primary care, it is unrealistic to expect them to successfully claim primary care as an exclusive field of practice. Specialist physicians, also in adequate supply in Quebec, are already engaged in primary care. They are present in 30 per cent of group practices (CSBE 2013). And many provide primary care in their private offices and from their hospital bases. This role should be more explicitly and frankly integrated into an upgraded model of primary care.

The contribution from internal medicine, paediatrics, obstetrics, gynaecology, geriatrics and perhaps other specialists should be regarded as full-fledged participation in a model of primary care. This is important as primary care should not be seen as under skilled and, somewhat relatedly, technology poor. The ascetic notion of primary care relying mostly on clinical sense that would only be a low-tech satellite activity of hospitals makes no sense for either physicians or patients.

10 The GMF program was launched with little thought given to devising a protocol for clinical nurses to work in cooperation with physicians in a primary-care setting, and nurse practitioners only became available almost seven years after the program was launched. Professional associations have organized seminars to discuss it and the University of Montreal nursing school eventually attempted to fill the void with a careful discussions of do's and don'ts but, to this day, the health ministry has provided no leadership or systematic monitoring of the implementation of this new model of primary care, including of the required training and coaching (Contandriopoulos 2013). Physicians were not shown how nursing and associated personnel could increase their productivity, leading physicians to feel that the plan to enrol 1,400 patients, on average, is unrealistically high (Beaulieu 2006).

11 A 2012 poll showed that more than one-half (52 percent) of the public have never heard of it while as few as 16 percent knew that a GMF existed in their neighbourhood and 18 percent were aware of the services it offers (Leger 2012). The health ministry website explains how to apply to become a registered patient but also clearly indicates that the result may be only to get on a waiting list (Quebec 2013).

*2. Compensation in Primary Care through Fee-for-Service Must Give Way to More Per-Patient Payments (capitation)*

Modern primary care that relies on a team approach cannot be paid for with fee-for-service payments. Ontario has moved decisively in the direction of paying for primary care through capitation, which now represents more than one-third (34.1 percent) of total physician payments compared with 0.2 percent in Quebec (CSBE 2012). Ontario's family-health team program expansion has been accompanied as well with a large increased in the number of enrolled patients (Blomqvist, Kralj and Kantarevic 2013). By paying Quebec family doctors on a per-patient basis, with pre-determined lump-sum amounts for every patient under their care, doctors would be encouraged to enrol a higher number of patients and engage in more preventative care (Blomqvist and Busby 2012). However, even though capitation should produce better incentives, like with any payment system, such potential will be realized only if enrolment targets are set and closely monitored.

There are many ways to introduce capitation-style payments to family doctors. Over 10 years ago, I suggested a "rostering system" under which each patient would register with a primary-care practice and pay the primary-care provider directly, with such payments to be eligible for a refundable tax credit (Forget 2001). This would give registered patients a more effective voice and standing vis-à-vis care providers, because they could shop for a group practice that lives up to their expectations and, if not, shift to a different group that does.[12]

*3. Primary Care Requires A Team Approach*

Family physicians must learn to work as members of a team. A team approach requires complementary resources including, but not limited to, nurses trained to take over a number of responsibilities, such as the ability to perform uncomplicated diagnoses and prescribe pharmaceuticals, that are part of comprehensive primary healthcare. Both physician and associated personnel must be trained to work as a team and within well-defined protocols that spell out to every team member his or her scope of practice and needed referrals.

## Common Challenges in Moving to an Ideal System

The concept of primary care described directly above and in the introduction of this *Commentary* reflects a near-consensus view among policy planners with regard to how health services in any country should work. Over time, and in many jurisdictions, policymakers have engaged in various experiments designed to turn the ideal into reality – the GMF reform in Quebec is a good example.[13] But the disappointing results of the GMF experiment demonstrate the difficulty of implementing the policy ideas underpinning this primary-care model. Yet, I strongly believe in the importance of a similar model for a better functioning of Quebec's healthcare system. It is, therefore, important to understand the obstacles standing in the way of these fundamentally good ideas.

12 Of course, patients should have to register with a group for only a short period, say three months. The face-to-face relationship between patients and care providers may be strengthened by a direct financial link between them.

13 In Quebec, the CLSCs belong in that class as well as analogous initiatives in other provinces, none of which became the trailblazers that their instigators had hoped for.

### The Blurred Line between Primary and Secondary Care

Healthcare has evolved to the point where many treatments that decades ago were considered tertiary care now belong to secondary care. Similarly, procedures previously considered as belonging to the secondary level are now considered part of primary care. With same-day surgery, home or birthing centre deliveries for low-risk pregnancies, broader management of chronic diseases and long-term care at home or in nursing homes, to name a few examples, the sharp distinction between the lone doctor in his office and the hospital belongs to the past.

A blurred dividing line between primary and secondary care need not be a bad thing, however, as greater efficiencies can be pursued across traditional boundaries. Today, good diagnostics often must combine quick access to laboratory tests and imaging services, but many primary-care systems relegate them to another level of care.

Reforms to primary care must also aim to improve the well-documented poor communication between primary-care providers and specialized services. On this score, Quebec – and Ontario, for that matter – performs badly on measures of care coordination between primary-care doctors and the rest of the health system, relative to other health jurisdictions as documented in Commonwealth Fund survey results (see Figure 5). For example, only about 10 percent of Quebec family doctors report being notified within 48 hours when one of their patients is discharged from a hospital, a figure much lower than in Europe (35 percent) or Ontario (20 percent).

Quebecers may appreciate the convenience of available primary-care services, but going to a doctor's office for things other than minor cuts and bruises and sore throats gives them no greater ease of access to specialized services, which they otherwise would get by going to ERs. This is reason to believe that even if sweeping reforms were brought to primary care, Quebecers might persist in going to ERs if the long wait affords faster access to specialized services.

### Shifting Resources from an Institution-Focus to a Patient-Focus

To enhance accessibility, both human and financial resources need to be refocused. Current health budgets and the associated professionals assigned to primary and secondary care and institutions must be seen as a single pool and their traditional uses looked at with a critical and demanding mindset.[14]

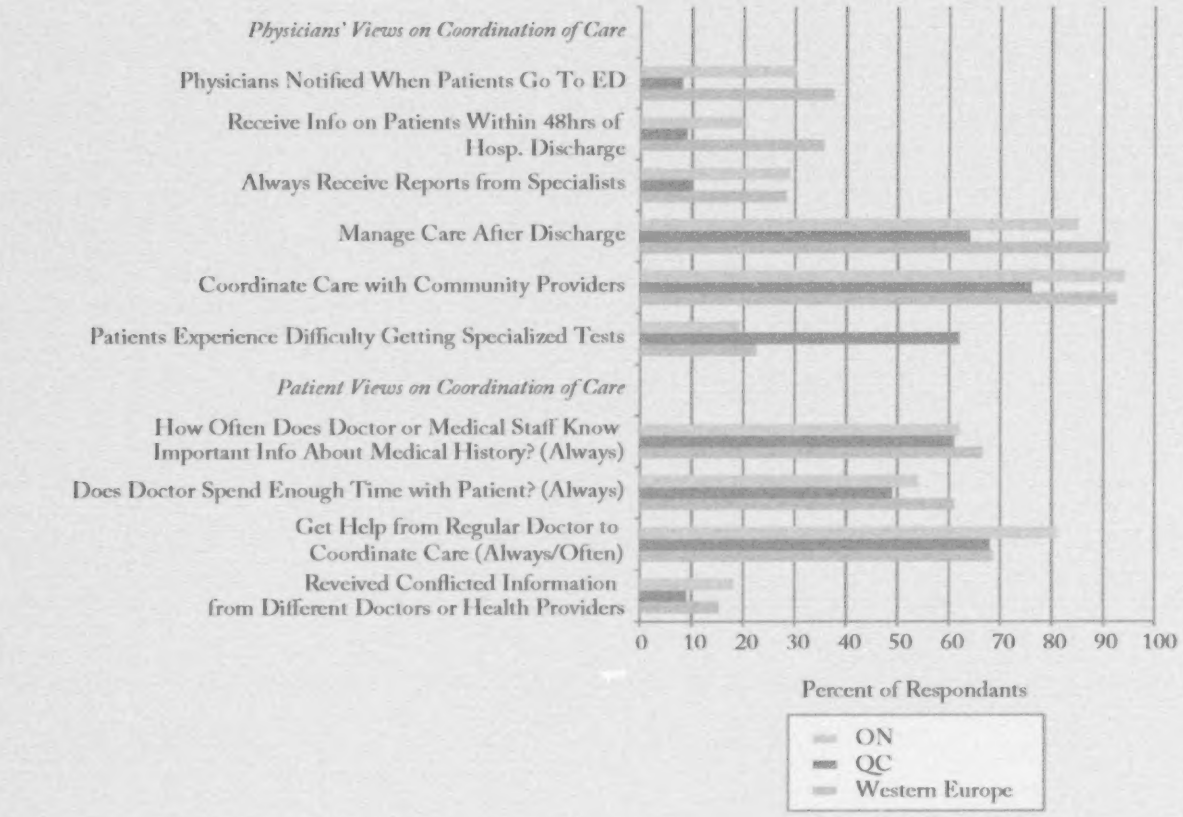
In the last decade, Quebec has merged community hospitals, chronic care institutions and CLSCs and even the staff support for GMFs under common regional umbrellas.[15] This move was motivated by the need to seek synergies and greater efficiency. But this measure must be coupled with a financial framework that pays for services that are patient priorities rather than priorities that finance the survival of long-standing institutions.

Conceptually, an emphasis on greater capitation payments for taking responsibility for more patients and activity payments progressively tied to outcomes should provide an important basis for change among primary caregivers. But there also needs to be a better financing method that accounts for patients' priorities across levels of care and

14 As minister, this author remembers "union" opposition to family physician groups striking separate deals to explore innovative primary-care delivery approaches within the CLSC framework.

15 An evaluation of these structures is beyond the scope of this *Commentary*.

**Figure 5: Coordination of Care – Physician and Patient Views**


Physicians' Views on Coordination of Care
Physicians Notified When Patients Go To ED
Receive Info on Patients Within 48hrs of Hosp. Discharge
Always Receive Reports from Specialists
Manage Care After Discharge
Coordinate Care with Community Providers
Patients Experience Difficulty Getting Specialized Tests
Patient Views on Coordination of Care
How Often Does Doctor or Medical Staff Know Important Info About Medical History? (Always)
Does Doctor Spend Enough Time with Patient? (Always)
Get Help from Regular Doctor to Coordinate Care (Always/Often)
Received Conflicted Information from Different Doctors or Health Providers
0 10 20 30 40 50 60 70 80 90 100
Percent of Respondants
ON
QC
Western Europe

Sources: HCC (2014, 2013) and CSBE (2012b).

institutional boundaries. I believe that primary-care organizations could evolve to take on a leading role in marshalling public healthcare resources to serve patient needs by becoming the channel through which other service providers obtain their financing (Forget and Forget 1998).

Under this type of "extended" capitation system, primary-care providers would have budgetary control over some secondary-care services such as diagnostic imaging, short hospital stays, outpatient surgery, etc. By giving primary-care provider groups greater control to purchase other health services on behalf of their patients, this would improve the incentives for coordinating primary, secondary and community support services in a way that enhances value for money. This option – a version of which is currently being pursued in the United Kingdom – may look more attractive now that other approaches have demonstrated their limitations. A move of this nature needs a time of transition but, in the end, is essential to success.

### Provider Buy-in

The shift in healthcare financing from processes and activities to outcomes requires a gradual shift from fee-for-service payments, a long-standing model that is difficult to move away from but which has incentives that are poorly aligned with efficient primary-care delivery. A revised physician-payment system should be based on a model that encourages patient enrolment and clearly states the desired services and delivery. Capitation – per-patient – payments for doctors should encourage greater enrolment. Such a remuneration scheme would also need to reflect a team approach for care while gradually moving toward outcomes-based bonuses and penalties.

Perhaps it is because of doctors' long history with fee-for-service payments that primary-care reform has few champions in Canada from within the medical profession. Furthermore, it may be because of the divisions of labour assigned under traditional primary-care systems that doctors are reluctant to concede some of their traditional services, and their related fees, to other caregivers. Even though some physicians are supportive of change – team-based care with larger capitated payments represents an immense opportunity for an innovative and efficient primary-care program – their professional leadership has often been cool or even opposed.

This is particularly true in Quebec where primary-care physicians have their own strong advocacy group, separated from that of specialists, that makes it difficult to drive reforms on a large scale. A resistance to patient enrolment and the capitation mode of payment has arguably been a factor in the slow development of GMFs and low enrolment rate of patients.

Indeed, roughly 70 percent of Quebec family doctors rely on fee-for-service as their main funding arrangement, while only 12 percent report having a capitation and blended payment model (HCC 2014). The opposite is true in Ontario, where roughly 55 percent of family physicians report having either a capitation or a blended capitation model as their main payment vehicle, and only 38 percent report relying on fee-for-service (HCC 2014). The medical profession's reluctance to change reduces the likelihood that an effective primary-care program will be implemented, but it must be overcome if healthcare is to reflect the best hopes of the public and policymakers.

### Public Awareness of Change

The iconic nature of public-health services requires that change be accompanied by a major effort at public education and persuasion. The development of primary care, such as it has been, seems to be largely a supply-side effort inspired by policy planners without a correspondingly strong demand-side pressure from the general public.

Many Quebecers, and Canadians for that matter, are accustomed to visiting hospital emergency rooms for immediate access to care – this is, after all, the location to which our health system steered them for decades. In view of that, a clear notion of primary-care reform must be explained to the public in terms of how change will drive better, more accessible and consistent services with adequate resources.

Despite these challenges, Quebec's healthcare system must undergo a substantial transformation. A new emphasis on a patient-centred approach and commitment to evidence-based services would help the healthcare system, which has resisted change, come to grips with the constant escalation of costs, challenging the current, unsatisfactory access to primary care and service delivery.

## Conclusions and Recommendations

> "EDs represent a fascinating environment for young doctors. It is a world where you get immediate results, were you feel efficient. [...] EDs in addition have a precious advantage: a work period that has a beginning and an end. It is not necessarily the case

> at the office with lab results to check, calls to make, etc." – Dr. Guylaine Laguë, president, young doctors committee, FMOQ (Garnier 2013).

EDs dominate not only the aspirations of many Quebec doctors but also policy planning at the province's ministry of health. There is little surprise that members of the general public consider EDs their only recourse when they need to access the system. But this arrangement is expensive, inconvenient for patients and provides slow access to care. It ought to change.

The current emphasis on reforming primary care should also shift family physicians more in the direction of community-based practices. In order to provide same-day or next-day availability, home visits, off-hours availability, rapid response to telephone consultations, etc., the Quebec government as a first step must make compensation levels in the primary-care system at least as advantageous as those in the hospital system.

Although family physicians are in more abundant supply in Quebec than in Ontario, getting access to their services has remained difficult. GMFs are a well-intended, but half-hearted, attempt at primary-care reform that has failed to bring about a remedy. An effective primary-care model for the entire population requires more serious changes. More attention should be paid to the mix of health professionals that make up family-health teams, where they will come from, how they will be trained and how they can be induced to take up the accessibility challenge.

On this score, financing these teams through a mixed capitation system that encourages patient mobility, registering with family doctors and physician accountability in meeting access benchmarks should go a long way to strengthen the pursuit of better access for patients. Such a model could be extended in the future to allow primary-care givers greater budgetary control to purchase some basic services on behalf of their patients.

Beyond this, physician commitment to enhanced availability vis-à-vis registered patients must grow. International results show that even with higher numbers of patients per doctor, access and coordination of care can improve without sacrificing quality.

Previous attempts to reform primary-care policy in Quebec covered, in principle, all the required bases: an expanded field of practice for nurses and pharmacists; a recognition of the need for patient enrolment; a recognition of the need to support enhanced staffing; better electronic patient records to improve the coordination of care; and an officially supportive attitude from the relevant medical association. These are necessary but clearly insufficient. The results, thus far, are meagre. A renewed, determined effort with stronger financial incentives and commitment from governments and providers is required.

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